2011 WL 6738532 (Ill.Cir.) (Trial Pleading)
Circuit Court of Illinois,
County Department, Law Division.
Cook County

Humberto RAMOS, Independent Administrator of the Estate of Elsa Ramos, (Deceased), Plaintiff,
v.
CENTER HOME FOR HISPANIC **ELDERLY** NORTH, LLC Extended Care Consulting, LLC, Center Home Property, LLC, Eric Rothner, Defendants.

No. 2011-L-007477.
2011.

Plaintiff's Complaint at Law

Jeffrey Schlapp, Horwitz, Horwitz and Associates, Ltd., 25 E. Washington, Suite 900, Chicago, Illinois 60602, (312) 372-8822, fax: (312) 372-1673.

NOW COMES the Plaintiff HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE STATE OF ELSA RAMOS (DECEASED), by his attorneys HORWITZ, HORWITZ AND ASSOCIATES, LTD., and complaining of the Defendant's, Center Home for Hispanic **Elderly** North, LLC, Eric Rothner, Extended Care Consulting, LLC, and Center Home Property, LLC, alleges as follows:

COUNT I - CENTER HOME FOR HISPANIC ELDERLY NORTH, LLC (ILLINOIS NURSING HOME CARE ACT)

1. This count is brought pursuant to the Illinois Nursing Home Care Act, 210 ILCS 45/1-101 et seq.
2. That on or about July 21, 2009, and prior thereto, the Defendant, Center Home for Hispanic **Elderly** North, LLC, (hereinafter referred to as "Center Home for Hispanic **Elderly**"), owned, possessed, operated, managed, maintained, and controlled and/or had a duty to possess, operate, manage, maintain and control, both directly and indirectly, individually and through their agents, servants and employees, certain premises which included a certain facility and facility staff located at approximately 1401 North California, Chicago (60622), County of Cook and State of Illinois.

3. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was an Illinois for-profit corporation.

4. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, held itself out to the public at large as specialist providing skilled nursing care and intermediate nursing services in the field of nursing care.

5. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was licensed as a skilled care facility and was the Licensee.

6. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was licensed to accept Medicare Residents.

7. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was a "skilled nursing facility," as that term is defined by 42 U.S.C. 1395i-3.

8. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was subject to the requirements and standards set forth at 42 U.S.C. 1395i-3.

9. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, understood that it was subject to the requirements and standards set forth at 42 U.S.C. 1395i-3.

10. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, agreed that it would comply with all applicable federal and state laws, rules, and regulations governing a "skilled nursing facility".

11. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was licensed to accept Medicaid Residents.

12. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was a "nursing facility," as that term is defined by 42 U.S.C. 1396r.

13. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, was subject to the requirements and standards set forth at 42 U.S.C. 1396r.

14. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, understood that it was subject to the requirements and standards set forth at 42 U.S.C. 1396r.

15. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly**, agreed that it would comply with all applicable federal and state laws, rules, and regulations governing a "nursing facility".

16. At all times relevant hereto, Center Home for Hispanic **Elderly** was a "facility" as that term is defined by 42 C.F.R. §483.5.

17. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly** was subject to the requirements and standards set forth at 42 C.F.R. §483.

18. At all times relevant hereto, Defendant, Center Home for Hispanic **Elderly** understood that it was subject to the requirements set forth at 42 C.F.R. §483.

19. At all times relevant hereto, 42 C.F.R. §483.20 provided, *inter alia:* The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

20. At all times relevant hereto, 42 C.F.R. §483.25 provided, *inter alia:* Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

21. At all times relevant hereto, 42 C.F.R. §483.30(a) provided, *inter alia:* The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

22. At all times relevant hereto, 42 C.F.R. §483.75(f) provided: The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments, and described in the plan of care.

23. At all times relevant hereto there existed a statute known as the Illinois Nursing Home Care Act, 210 ILCS 45/1-101 et seq. (hereafter "the Act")

24. At all times relevant hereto, Center Home for Hispanic **Elderly** was a "facility" as that term is defined by 45/1-113 of the Act.

25. At all times relevant hereto, 210 ILCS 45/2-107 provided, *inter alia:* "An owner, licensee, administrator, employee or agent of a facility shall not abuse or **neglect** a resident.

26. At all times relevant hereto, 210 ILCS 45/1-117 provided: "**Neglect**" means a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition.

27. At all times relevant hereto, 210 ILCS 45/3-601 provided: "The owner and licensee are liable to a resident for any intentional or negligent act or omission of their agents or employees which injures the resident."

28. At all times relevant hereto, Center Home for Hispanic **Elderly** was required to comply with the Act.

29. At all times relevant hereto, Center Home for Hispanic **Elderly** understood that it was required to comply with the Act.

30. At all times relevant hereto, 210 ILCS 45/3-801 provided: "The Department [of Public Health] shall have the power to adopt rules and regulations to carry out the purpose of this Act."

31. At all times relevant hereto, Center Home for Hispanic **Elderly** was required to comply with the rules and regulations of the Illinois Department of Public Health.

32. At all times relevant hereto, Center Home for Hispanic **Elderly** understood that it was required to comply with the rules and regulations of the Illinois Department of Public Health.

33. At all times relevant hereto, 77 Ill. Admin, Code. CH I, 300. 610(a) provided: The facility shall have written polices and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

34. At all times relevant hereto, 77 111. Admin. Code. CH I, 300. 690(a) provided, *inter alia:* The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents.

35. At all times relevant hereto, 77 Ill. Admin. Code, Ch. 1, 300.1010(h) provided: The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety, or welfare of a resident, including but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

36. At all times relevant hereto, 77 111. Admin. Code, Ch. I, 300.1210(a) provided, *inter alia:* The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

37. At all times relevant hereto, 77 Ill. Admin. Code. Ch. I, 300.1210(b)(1) provided: General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.

38. At all times relevant hereto, 77 Ill. Admin. Code. Ch. I, 300.1210(b)(2) provided: General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: All treatments and procedures shall be administered as ordered by the Physician.

39. At all times relevant hereto, 77 Ill. Admin. Code. Ch. 1, 300.1210(b)(6) provided: All necessary precautions shall be taken to assure that the residents environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

40. At all times relevant hereto, 77 Ill. Admin. Code. Ch. I, 300.1230(c) provided: It is the responsibility of each facility to determine the staffing needed to meet the needs of its residents.

41. On or about May 12, 2008, Elsa Ramos was admitted as a resident to Defendant, Center Home for Hispanic **Elderly**.

42. On or about May 12, 2008, Center Home for Hispanic **Elderly** accepted Elsa Ramos as a resident.

43. On or about July 21, 2009, and prior thereto, Elsa Ramos was a resident of Center Home for Hispanic **Elderly**.

44. Elsa Ramos relied on Defendant, Center Home for Hispanic **Elderly** for adequate and proper nursing and personal care.

45. Center Home for Hispanic **Elderly** knew or should have known that Elsa Ramos relied on Defendant, Center Home for Hispanic **Elderly** for adequate and proper nursing and personal care.

46. Upon her admission to the Defendant, Center Home for Hispanic **Elderly**, Elsa Ramos had a medical history that included: Parkinson's, TIA, seizure disorder, arterial stenosis, and urinary retention.

47. Defendant, Center Home for Hispanic **Elderly**, knew or should have known Elsa Ramos's medical history when it accepted her as a resident to the facility.

48. On or about May 12, 2009 up to and including July 21,2009, the Defendant, Center Home for Hispanic **Elderly**, assessed Elsa Ramos as being at high risk for skin breakdown.

49. On or about May 12, 2009 up to and including July 21, 2009, the Defendant, Center Home for Hispanic **Elderly**, assessed Elsa Ramos as requiring assistance with all of her activities of daily living.

50. On or about May 12, 2009 up to and including July 21, 2009, the Defendant, Center Home for Hispanic **Elderly**, assessed Elsa Ramos as requiring turning and/or repositioning every 2-hours due to her high risk for skin breakdown.

51. On or about May 13, 2009, the Defendant, Center Home for Hispanic **Elderly**, assessed Elsa Ramos as exhibiting reddness to her perineal area as well as her buttocks.

52. On or about May 12, 2009 up to and including July 21, 2009, the Defendant, Center Home for Hispanic **Elderly**, knew or should have known Elsa Ramos required daily skin checks due to her ongoing development of pressure sores to her lower extremities.

53. On or about May 12, 2009 up to and including July 21, 2009, the Defendant, Center Home for Hispanic **Elderly**, knew or should have known to inform Elsa Ramos physician of any signficant change exhibited by Elsa Ramos.

54. On or about May 12, 2009 up to and including July 21, 2009, the Defendant, Center Home for Hispanic **Elderly**, documented that Elsa Ramos was dependent upon G-tube feeding for her nutrition.

55. On or about May 12, 2009 up to and including July 21, 2009, the Defendant, Center Home for Hispanic **Elderly**, knew or should have known a resident receiving G-tube feeding was at risk for aspiration pneumonia.

56. On or about July 21, 2009, Elsa Ramos was admitted to Sacred Heart Hopsital.

57. On or about July 21, 2009, Elsa Ramos medical team at Sacred Heart Hospital diagnosed Ms. Ramos with: aspiration penumonia, MRSA, Stage IV pressure sore to her coccyx; and pressure sores to her bilateral heels.

58. Defendant, Center Home for Hispanic **Elderly**, had a duty to ensure Elsa Ramos was properly and accurately assessed while she was a resident.

59. Defendant, Center Home for Hispanic **Elderly**, had a duty to conduct a functional capacity assessment of Elsa Ramos initially and periodically.

60. Defendant, Center Home for Hispanic **Elderly**, had a duty to ensure Elsa Ramos was not subject to **neglect** while she was a resident.

61. Defendant, Center Home for Hispanic **Elderly**, had a duty to provide the care and services necessary for Elsa Ramos to attain or maintain her highest practicable well-being.

62. Defendant, Center Home for Hispanic **Elderly**, had a duty to have sufficient nursing staff to provide nursing and related services for Elsa Ramos to attain or maintain her highest practicable well-being.

63. Defendant, Center Home for Hispanic **Elderly**, had a duty to ensure nurse's aides were able to demonstrate competence in skills and techniques necessary to care for Elsa Ramos's needs.

64. Defendant, Center Home for Hispanic **Elderly**, had a duty to provide Elsa Ramos adequate and properly supervised nursing care and personal care.

65. Defendant, Center Home for Hispanic **Elderly**, had a duty to administer Elsa Ramos's medications properly.

66. Defendant, Center Home for Hispanic **Elderly**, had a duty to provide adequate supervision and assistance to prevent accidents.

67. Defendant, Center Home for Hispanic **Elderly**, had a duty to follow the orders of Elsa Ramos's physician.

68. Defendant, Center Home for Hispanic **Elderly**, had a duty to provide proper and adequate wound care to Elsa Ramos.

69. Notwithstanding its duties during the period of Elsa Ramos's residency at Defendant, Center Home for Hispanic **Elderly's** skilled nursing facility, Defendant, Center Home for Hispanic **Elderly** by its officers, agents, employees, and staff, violated the provisions of 210 ILCS 45/2-107 by one or more of the following negligent acts and/or omissions by failing to:

a) A Resident Care Policy Committee did not develop the Defendant, Center Home for Hispanic **Elderly's** written policies and procedures and the policies that were in place were not reviewed annually nor did they comply with the rules promulgated under the Act;

b) Lacked policies and procedures to address the proper intervention and care for a resident with developing pressure ulcers;

c) Failed to document nursing care on a regular basis;

d) Failed to report its failure to document nursing care on a regular basis;

e) Failed to properly measure Elsa Ramos's developing pressure sores;

f) Failed to ensure Elsa Ramos's developing pressure sores were properly treated;

g) Failed to report its failure to properly measure Elsa Ramos's developing pressure sores;

h) Failed to follow infection control procedures;

i) Failed to properly train its nursing staff in proper infection control procedures;

j) Failed to ensure Elsa Ramos daily caregiver were informed as to her Careplan goals;

k) Failed to report its failure to follow Elsa Ramos's wound care orders from her physician;

l) Failed to ensure Elsa Ramos's physician was notified of the proper measurements of Elsa Ramos's increasing pressure sores;

m) Failed to ensure Elsa Ramos's physician was notified that each and every wound care order received regarding Elsa Ramos was not performed;

n) Failed to ensure stall informed Elsa Ramos's physician of the staff's failure to follow Elsa Ramos's wound care treatment;

o) Failed to provide adequate and properly supervised nursing personnel;

p) Failed to ensure its staff properly administered Elsa Ramos's wound care treatments;

q) Failed to ensure its facility was properly staffed according to the needs of its residents;

r) Failed to inform Elsa Ramos's physician of her significant change in development of pressure sores;

s) Failed to conduct periodically a comprehensive, accurate assessment of functional capacity for Elsa Ramos;

t) Failed to provide the necessary care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

u) Failed to create a comprehensive assessment to provide the necessary adequate and proper personal care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

v) Failed to have sufficient nursing staff to provide nursing and related services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

w) Failed to ensure its nurse aides were able to demonstrate competency in skills and techniques necessary to care for Elsa Ramos's needs;

70. As a direct and proximate result of one or more of the Defendant, Center Home for Hispanic **Elderly's** statutory violations and/or deviation from the standard of care of a reasonable nursing home, Elsa Ramos suffered from: aspiration pneumonia,

MRSA, Stage IV pressure sore to her coccyx; and pressure sores to her bilateral heels, which subsequently led to Ms. Ramos requiring painful surgical procedures and mechanical ventilation.

71. As a direct result thereof, Elsa Ramos suffered pecuniary and personal loss including but not limited to disability, pain and suffering, loss of normal life, and expenses for medical care.

WHEREFORE, the Plaintiff, HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE ESTATE OF ELSA RAMOS (DECEASED), prays for judgment against the Defendant, Center Home for Hispanic **Elderly** Nursing & Rehabilitation Centre, Ltd., in an amount sufficient to satisfy jurisdictional requirements and other relief the Court deems just and proper, including all relief authorized by Section 3-602 of the Nursing Home Care Act, and costs of suit. Plaintiff demands trial by jury.

COUNT II - EXTENDED CARE CONSULTING, LLC (ILLINOIS NURSING HOME CARE ACT)

1. This count is brought pursuant to the Illinois Nursing Home Care Act, 210 ILCS 45/1-101 et seq.
2. That on or about July 21, 2009, and prior thereto, the Defendant, Extended Care Consulting, LLC, (hereinafter referred to as “Extended Care”), owned, possessed, operated, managed, maintained, and controlled and/or had a duty to possess, operate, manage, maintain and control, both directly and indirectly, individually and through their agents, servants and employees, certain premises which included a certain facility and facility staff located at approximately 1401 North California, Chicago (60622), County of Cook and State of Illinois.

3. At all times relevant hereto, Defendant, Extended Care, was an Illinois for-profit corporation.

4. At all times relevant hereto, Co-Defendant, Center Home for Hispanic **Elderly**, was licensed as a skilled care facility.

5. At all times relevant hereto, Defendant, Extended Care, owned, possessed, operated, managed, maintained, controlled and/or had a duty to possess, operate, manage, maintain, control, directly and/or indirectly, individually and/or through agents, servants and/or employees, a skilled nursing facility, Center Home for Hispanic **Elderly**, which held itself out to the public at large as specialist providing skilled nursing care and intermediate nursing services in the field of nursing care.

6. Plaintiff repeats and re-alleges paragraphs 6-69 of Count I as and for paragraphs 6- 69 of Count 11 as though fully set forth herein.

70. At all times relevant hereto, Extended Care knew or should have known of the aforementioned acts and/or omissions of Center Home for Hispanic **Elderly**.

71. At all times relevant hereto, Extended Care, and Center Home for Hispanic **Elderly**, were related parties.

72. At all times relevant hereto, Extended Care did not provide hands-on care to the residents of Center Home for Hispanic **Elderly**, including Elsa Ramos.

73. At all times relevant hereto, Extended Care, employed, contracted with and/or controlled social service consultants), activity consultant(s), physical therapist(s), occupational therapist(s), speech therapist(s) and Center Home for Hispanic **Elderly's**, medical director.

74. At all times relevant hereto, there was a contract between Extended Care, and Center Home for Hispanic **Elderly**, whereby Extended Care would provide consultative services related to patient care, budgets, supervision of executive staff, employment of direct care staff, policies and procedures, vendor agreements.

75. At all times relevant hereto, Extended Care, owed a duty to act as a reasonably well-qualified nursing home management company to each and every resident of Center Home for Hispanic **Elderly** including Elsa Ramos.

76. Defendant, Extended Care, had a duty to ensure Center Home for Hispanic **Elderly**, discharged all of its duties, responsibilities and obligations owed Elsa Ramos and similarly situated residents.

77. Notwithstanding its duties, at all relevant times hereto while it was managing Center Home for Hispanic **Elderly**, Extended Care, was negligent when it permitted conditions to exist thereby allowing one or more of the following negligent acts and/or omissions and/or violations of the standard of care at Center Home for Hispanic **Elderly**:

a) A Resident Care Policy Committee did not develop the Defendant, Center Home for Hispanic **Elderly's** written policies and procedures and the policies that were in place were not reviewed annually nor did they comply with the rules promulgated under the Act;

b) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** lacked policies and procedures to address the proper intervention and care for a resident with developing pressure ulcers;

c) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to document nursing care on a regular basis;

d) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to document nursing care on a regular basis;

e) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to properly measure Elsa Ramos's developing pressure sores;

f) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's developing pressure sores were properly treated;

g) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to properly measure Elsa Ramos's developing pressure sores;

h) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to follow infection control procedures;

i) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to properly train its nursing staff in proper infection control procedures;

j) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos daily caregivers were informed as to her Careplan goals;

k) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to follow Elsa Ramos's wound care orders from her physician;

l) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's physician was notified of the proper measurements of Elsa Ramos's increasing pressure sores;

m) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's physician was notified that each and every wound care order received regarding Elsa Ramos was not performed;

n) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure staff informed Elsa Ramos's physician of the staffs failure to follow Elsa Ramos's wound care treatment;

o) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to provide adequate and properly supervised nursing personnel;

p) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its staff properly administered Elsa Ramos's wound care treatments;

q) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its facility was properly staffed according to the needs of its residents;

r) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to inform Elsa Ramos's physician of her significant change in development of pressure sores;

s) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to conduct periodically a comprehensive, accurate assessment of functional capacity for Elsa Ramos;

t) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to provide the necessary care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

u) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to create a comprehensive assessment to provide the necessary adequate and proper persona] care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

v) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to have sufficient nursing stall to provide nursing and related services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

w) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its nurse aides were able to demonstrate competency in skills and techniques necessary to care for Elsa Ramos's needs;

x) Engaged in Pre-planning in the operation of Center Home for Hispanic **Elderly** to induce the acts and/or omissions of a-w;

y) Organized and/or managed the facility so as to cause a-w.

78. As a direct and proximate result of one or more of the Defendant, Extended Care's statutory violations and/or deviation from the standard of care of a reasonable nursing home management company, Elsa Ramos suffered from: aspiration pneumonia, MRSA, Stage IV pressure sore to her coccyx; and pressure sores to her bilateral heels, which subsequently led to Ms. Ramos requiring painful surgical procedures and mechanical ventilation.

79. As a direct result thereof, Elsa Ramos suffered pecuniary and personal loss including but not limited to disability, pain and suffering, loss of normal life, and expenses for medical care.

WHEREFORE, the Plaintiff, HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE ESTATE OF ELSA RAMOS (DECEASED), prays for judgment against the Defendant, Extended Care Consulting, LLC, in an amount sufficient to satisfy jurisdictional requirements and other relief the Court deems just and proper, including all relief authorized by Section 3-602 of the Nursing Home Care Act, and costs of suit. Plaintiff demands trial by jury.

COUNT III - EXTENDED CARE CONSULTING, LLC (INSTITUTIONAL NEGLIGENCE)

1. Plaintiff brings Count III under a theory of Institutional Negligence.
2. Plaintiff repeats and re-alleges paragraphs 2 through 5 of Count 11 as and for paragraphs 2 through 5 of Count III, as though fully set forth herein.

6. At all times relevant hereto, Defendant, Extended Care owned a duty to Center Home for Hispanic **Elderly** patients, including Elsa Ramos, to provide proper and adequate fiancial resources to Center Home for Hispanic **Elderly** for the purpose of proper and adequate staffing and/or training of Center Home for Hispanic **Elderly's** nursing department.

7. At all times relevant hereto, Defendant, Extended Care voluntarily assumed the role of Center Home for Hispanic **Elderly's** parent company and/or held itself out to employees of Center Home for Hispanic **Elderly** as it's Parent Company.

8. At all times relevant hereto, Defendant, Extended Care did not provide healing arts to residents of Center Home for Hispanic **Elderly**, including Elsa Ramos.

9. Upon information and belief, at all times relevant hereto, Defendant, Extended Care mandated that Center Home for Hispanic **Elderly's** licensed nursing home Administrator receive approval from the Defendant, Extended Care prior to increasing staffing ratio's to meet the acuity level of Center Home for Hispanic **Elderly's** resident's care needs.

10. Upon information and belief, at all times relevant hereto, Defendant, Extended Care mandated that Center Home for Hispanic **Elderly** adhere to policies and procedures provided to Center Home for Hispanic **Elderly** by Extended Care when providing adequate care and treatment to each and every resident, including Elsa Ramos.

11. At all times relevant hereto, the Defendant, Extended Care knew or should have known of the existence of the rules and regulations as concerned the provision of adequate and proper care to nurisng home residents as set forth by the Illinois Department of Public Health.

12. At all times relevant hereto, the Defendant, Extended Care knew or should have known that Center Home for Hispanic **Elderly** required proper and adequate budgets and/or proper and adequate financial resources in order to adhere to the rules and regulations as concerned the provision of adequate and proper care to nurisng home residents as set forth by the Illinois Department of Public Health.

13. Notwithstanding its duties, and in addition to the foregoing allegations of negligence, the Defendant, Extended Care was negligent in one or more of the following ways:

a) failed to have policies or sufficient policies to ensure proper care of Elsa Ramos;

b) Glen Health failed to ensure Center Home for Hispanic **Elderly's** staff was aware and competent as concerned Center Home for Hispanic **Elderly's** nursing policies;

c) Mandadted that Center Home for Hispanic **Elderly** adhere to a budget which required Center Home for Hispanic **Elderly** to assign too many residents to Center Home for Hispanic **Elderly's** staff;

d) failed to have a sufficient budget in place for Center Home for Hispanic **Elderly's** staff to meet the needs of Center Home for Hispanic **Elderly** residents;

c) mandated that Center Home for Hispanic **Elderly** follow a budget created and provided to Center Home for Hispanic **Elderly** by this Defendant, Glen Health which provided insufficient finances for Center Home for Hispanic **Elderly** to provide adequate and proper nursing and personal care to each and every resident, including Elsa Ramos.

f) Failed to exercise reasonable skill and care in the selection, retention, and continuing evaluation of Center Home for Hispanic **Elderly's** Adminstrator in violation of Illinois Nursing Home regulations as set forth by the Illinois Department of Public Health;

g) Failed to exercise reasonable skill and care in the selection, retention, and continuing evaluation of Center Home for Hispanic **Elderly's** nursing department in violation of Illinois Nursing Home regulations as set forth by the Illinois Department of Public Health;

h) Failed to exercise reasonable skill and care in the administration of Center Home for Hispanic **Elderly** in a manner that enabled Center Home for Hispanic **Elderly** to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, including Elsa Ramos.

14. As a direct and proximate result of one or more of the Defendant, Extended Care's statutory violations and/or deviation from the standard of care of a reasonable nursing home management company, Elsa Ramos suffered from aspiration pneumonia, MRSA, Stage IV pressure sore to her coccyx; and pressure sores to her bilateral heels, which subsequently led to Ms. Ramos requiring painful surgical procedures and mechanical ventilation.

15. As a direct result thereof, Elsa Ramos suffered pecuniary and personal loss including but not limited to disability, pain and suffering, loss of normal life, and expenses for medical care.

WHEREFORE, the Plaintiff, HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE ESTATE OF ELSA RAMOS (DECEASED), prays for judgment against the Defendant, Extended Care Consulting, LLC, in an amount sufficient to satisfy jurisdictional requirements and other relief the Court deems just and proper. Plaintiff demands trial by jury.

COUNT IV - CENTER HOME PROPERTY, LLC (ILLINOIS NURSING HOME CARE ACT)

1. This count is brought pursuant to the Illinois Nursing Home Care Act, 210 ILCS 45/1 - 101 et seq.
2. That on or about July 21, 2009, and prior thereto, the Defendant, Center Home Property, LLC, (hereinafter referred to as “Center Home Property”), owned, possessed, operated, managed, maintained, and controlled and/or had a duty to possess, operate, manage, maintain and control, both directly and indirectly, individually and through their agents, servants and employees, certain premises which included a certain facility and facility staff located at approximately 1401 North California, Chicago (60622), County of Cook and State of Illinois.

3. At all times relevant hereto, Defendant, Center Home Property, was an Illinois for-profit corporation.

4. At all times relevant hereto, Co-Defendant, Center Home for Hispanic **Elderly**, was licensed as a skilled care facility.

5. At all times relevant hereto, Defendant, Center Home Property, owned, possessed, operated, managed, maintained, controlled and/or had a duty to possess, operate, manage, maintain, control, directly and/or indirectly, individually and/or through agents, servants and/or employees, a skilled nursing facility, Center Home for Hispanic **Elderly**, which held itself out to the public at large as specialist providing skilled nursing care and intermediate nursing services in the field of nursing care.

6. Plaintiff repeats and re-alleges paragraphs 6-69 of Count I as and for paragraphs 6- 69 of Count IV as though fully set forth herein.

70. At all times relevant hereto, Center Home Property knew or should have known of the aforementioned acts and/or omissions of Center Home for Hispanic **Elderly**.

71. At all times relevant hereto, Center Home Property, and Center Home for Hispanic **Elderly**, were related parties.

72. At all times relevant hereto, Center Home Property did not provide hands-on care to the residents of Center Home for Hispanic **Elderly**, including Elsa Ramos.

73. At all times relevant hereto, Center Home Property was the owner of the real property commonly refered to as Center Home for Hispanic Property

74. At all times relevant hereto, there was a contract between Center Home Property, and Center Home for Hispanic **Elderly**, whereby Center Home Property would provide consultative services related to patient care, budgets, supervision of executive staff, employment of direct care staff, policies and procedures, vendor agreements.

75. At all times relevant hereto, Center Home Property, owed a duty to act as a reasonably well-qualified nursing home management company to each and every resident of Center Home for Hispanic **Elderly** including Elsa Ramos.

76. Defendant, Center Home Property, had a duty to ensure Center Home for Hispanic **Elderly**, discharged all of its duties, responsibilities and obligations owed Elsa Ramos and similarly situated residents.

77. Notwithstanding its duties, at all relevant times hereto while it was managing Center Home for Hispanic **Elderly**, Center Home Property, was negligent when it permitted conditions to exist thereby allowing one or more of the following negligent acts and/or omissions and/or violations of the standard of care at Center Home for Hispanic **Elderly**:

a) A Resident Care Policy Committee did not develop the Defendant, Center Home for Hispanic **Elderly's** written policies and procedures and the policies that were in place were not reviewed annually nor did they comply with the rules promulgated under the Act;

b) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** lacked policies and procedures to address the proper intervention and care for a resident with developing pressure ulcers;

c) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to document nursing care on a regular basis;

d) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to document nursing care on a regular basis;

e) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to properly measure Elsa Ramos's developing pressure sores;

f) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's developing pressure sores were properly treated;

g) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to properly measure Elsa Ramos's developing pressure sores;

h) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to follow infection control procedures;

i) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to properly train its nursing staff in proper infection control procedures;

j) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos daily caregivers were informed as to her Careplan goals;

k) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to follow Elsa Ramos's wound care orders from her physician;

l) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's physician was notified of the proper measurements of Elsa Ramos's increasing pressure sores;

m) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's physician was notified that each and every wound care order received regarding Elsa Ramos was not performed;

n) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure staff informed Elsa Ramos's physician of the staffs failure to follow Elsa Ramos's wound care treatment;

o) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to provide adequate and properly supervised nursing personnel;

p) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its staff properly administered Elsa Ramos's wound care treatments;

q) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its facility was properly staffed according to the needs of its residents;

r) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to inform Elsa Ramos's physician of her significant change in development of pressure sores;

s) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to conduct periodically a comprehensive, accurate assessment of functional capacity for Elsa Ramos;

t) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to provide the necessary care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

u) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to create a comprehensive assessment to provide the necessary adequate and proper personal care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

v) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to have sufficient nursing staff to provide nursing and related services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

w) Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its nurse aides were able to demonstrate competency in skills and techniques necessary to care for Elsa Ramos's needs;

x) Engaged in Pre-planning in the operation of Center Home for Hispanic **Elderly** to induce the acts and/or omissions of a-w;

y) Organized and/or managed the facility so as to cause a-w.

78. As a direct and proximate result of one or more of the Defendant, Center Home Property's statutory violations and/or deviation from the standard of care of a reasonable nursing home management company and/or owner of real property, Elsa Ramos suffered from: aspiration pneumonia, MRSA, Stage IV pressure sore to her coccyx; and pressure sores to her bilateral heels, which subsequently led to Ms. Ramos requiring painful surgical procedures and mechanical ventilation.

79. As a direct result thereof, Elsa Ramos suffered pecuniary and personal loss including but not limited to disability, pain and suffering, loss of normal life, and expenses for medical care.

WHEREFORE, the Plaintiff, HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE ESTATE OF ELSA RAMOS (DECEASED), prays for judgment against the Defendant, Center Home Property Consulting, LLC, in an amount sufficient to satisfy jurisdictional requirements and other relief the Court deems just and proper, including all relief authorized by Section 3-602 of the Nursing Home Care Act, and costs of suit. Plaintiff demands trial by jury.

COUNT V - ERIC ROTHNER (ILLINOIS NURSING HOME CARE ACT)

1. This count is brought pursuant to the Illinois Nursing Home Care Act, 210 ILCS 45/1-101 et seq.
2. That on or about July 21, 2009, and prior thereto, the Defendant, Eric Rothner (hereinafter “Rothner”) owned, possessed, operated, managed, maintained, and controlled and/or had a duty to possess, operate, manage, maintain and control, both directly and indirectly, individually and through his agents, servants and employees, certain premises which included a certain facility and facility staff located at approximately 1401 North California, Chicago (60622), County of Cook and State of Illinois.

3. At all times relevant hereto, Defendant, Rothner, owned, possessed, operated, managed, maintained, and controlled and/or had a duty to possess, operate, manage, maintain and control, both directly and indirectly, individually and through his agents, servants and employees, certain premises which included a certain facility and facility staff located at approximately 1401 North California, Chicago (60622), County of Cook and State of Illinois, which was an Illinois for-profit corporation.

4. At all times relevant hereto, Defendant, Rothner, owned, possessed, operated, managed, maintained, and controlled and/or had a duty to possess, operate, manage, maintain and control, both directly and indirectly, individually and through his agents, servants and employees, certain premises which included a certain facility and facility staff located at approximately 1401 North California, Chicago (60622), County of Cook and State of Illinois, which was licensed as a skilled care facility.

5. At all times relevant hereto, Defendant, Rothner, owned, possessed, operated, managed, maintained, controlled and/or had a duty to possess, operate, manage, maintain, control, directly and/or indirectly, individually and/or through agents, servants and/or employees, a skilled nursing facility, Center Home for Hispanic **Elderly**, which held itself out to the public at large as specialist providing skilled nursing care and intermediate nursing services in the field of nursing care.

6. Plaintiff repeats and re-alleges paragraphs 6-69 of Count I as and for paragraphs 6- 69 of Count V as though fully set forth herein.

70. At all relevant times hereto, Defendant, Rothner knew or should have known of the aforementioned acts and/or omissions of Center Home for Hispanic **Elderly**.

71. At all relevant times hereto, Defendant, Rothner was the majority shareholder of Center Home for Hispanic **Elderly**.

72. At all relevant times hereto, Defendant, Rothner was a member of Center Home for Hispanic **Elderly's** Governing Board.

73. At all relevant times hereto, Defendant, Rothner mandated that.Center Home for Hispanic **Elderly** contract with Extended Care as part of Defendant, Rothner's scheme to place personal profit over the care of Center Home for Hispanic **Elderly's** residents.

74. At all relevant times hereto, Defendant, Rothner mandated that Center Home for Hispanic **Elderly** contract with Center Home Property, as part of Defendant, Rothner's scheme to place personal profit over the care of Center Home for Hispanic **Elderly's** residents.

75. At all relevant times hereto, Defendant, Rothner held himself out to the employees of Center Home for Hispanic **Elderly** as the owner of Center Home for Hispanic **Elderly**.

76. At all relevant times hereto, Defendant, Rothner held himself out to the employees of Center Home for Hispanic **Elderly** as the owner of Extended Care.

77. At all relevant times hereto, Defendant, Rothner owed a duty to act as a reasonably well-qualified nursing home owner/ operator to the residents of Center I home for Hispanic **Elderly**, including, Elsa Ramos.

78. Defendant, Rothner had a duty to ensure Center I tome for Hispanic **Elderly** discharged all of its duties, responsibilities, and obligations owed Elsa Ramos and similarly situated residents.

79. Notwithstanding his duties, Defendant, Rothner was negligent in allowing one or more of the following negligent acts and/ or omissions and/or violations of the standard of care at Center Home for Hispanic **Elderly**:

a. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** lacked policies and procedures to address the proper intervention and care for a resident with developing pressure ulcers;

b. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to document nursing care on a regular basis;

c. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to document nursing care on a regular basis;

d. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to properly measure Elsa Ramos's developing pressure sores;

e. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's developing pressure sores were properly treated;

f. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to properly measure Elsa Ramos's developing pressure sores;

g. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to follow infection control procedures;

h. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to properly train its nursing staff in proper infection control procedures;

i. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos daily caregivers were informed as to her Careplan goals;

j. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to report its failure to follow Elsa Ramos's wound care orders from her physician;

k. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's physician was notified of the proper measurements of Elsa Ramos's increasing pressure sores;

l. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure Elsa Ramos's physician was notified that each and every wound care order received regarding Elsa Ramos was not performed;

m. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure staff informed Elsa Ramos's physician of the staffs failure to follow Elsa Ramos's wound care treatment;

n. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to provide adequate and properly supervised nursing personnel;

o. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its staff properly administered Elsa Ramos's wound care treatments;

p. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its facility was properly staffed according to the needs of its residents;

q. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to inform Elsa Ramos's physician of her significant change in development of pressure sores;

r. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to conduct periodically a comprehensive, accurate assessment of functional capacity for Elsa Ramos;

s. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to provide the necessary care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

t. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to create a comprehensive assessment to provide the necessary adequate and proper persona] care and services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

u. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to have sufficient nursing staff to provide nursing and related services to allow Elsa Ramos to attain or maintain her highest practicable physical, mental, and psychosocial well-being;

v. Permitted conditions to exist wherein Center Home for Hispanic **Elderly** failed to ensure its nurse aides were able to demonstrate competency in skills and techniques necessary to care for Elsa Ramos's needs;

w. Engaged in Pre-planning in the operation of Center Home for Hispanic **Elderly** to induce the acts and/or omissions of a-v;

x. Organized and/or managed the facility so as to cause a-v;

y. Engaged in Pre-planning in the operation of Co-Defendant, Extended Care to induce the acts and/or omissions of a-v;

z. Organized and/or managed Co-Defendant, Extended Care so as to cause a-v;

80. As a direct and proximate result of one or more of the Defendant, Rothner's statutory violations and/or deviation from the standard of care of a reasonable nursing home owner/operator and/or Governing Body member, Elsa Ramos suffered from: aspiration pneumonia, MRSA, Stage IV pressure sore to her coccyx; and pressure sores to her bilateral heels, which subsequently led to Ms. Ramos requiring painful surgical procedures and mechanical ventilation.

81. As a direct result thereof, Elsa Ramos suffered pecuniary and personal loss including but not limited to disability, pain and suffering, loss of normal life, and expenses for medical care.

WHEREFORE, the Plaintiff, HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE ESTATE OF ELSA RAMOS (DECEASED), prays for judgment against the Defendant, Eric Rothner in an amount sufficient to satisfy jurisdictional requirements and other relief the Court deems just and proper, including all relief authorized by Section 3-602 of the Nursing Home Care Act, and costs of suit. Plaintiff demands trial by jury.

COUNT VI - ERIC ROTHNER (DIRECT PARTICIPANT LIABILITY)

1. Plaintiff brings count VI under a Direct Participant Liability theory of recovery.
2. Plaintiff repeats and re-alleges 2 through 79 of Count V as and for paragraphs 2 through 79 of Count V] as though fully set forth herein.

80. At all relevant times her eto, Defendant, Eric Rothner created a scheme to deceive the public as to the true corporate structure of Center Home for Hispanic **Elderly**.

81. At all relevant times hereto, Defendant, Eric Rothner held himself out to the employees of Center Home for Hispanic **Elderly** as the owner of Center Home for Hispanic **Elderly**.

82. At all relevant times hereto, Department Heads of Center Home for Hispanic **Elderly** viewed Defendant, Eric Rothner as the owner of Center Home for Hispanic **Elderly**.

83. At all relevant times hereto, Defendant, Eric Rothner maintained direct control over the overall operation of Center Home for Hispanic **Elderly**.

84. At all relevant times hereto, Defendant, Eric Rothner actively participated in the affairs of Center Home for Hispanic **Elderly** in a way that placed Center Home for Hispanic **Elderly** residents, including Elsa Ramos, at risk for injury.

85. At all relevant times hereto, Defendant, Eric Rothner maintained direct control over the overall operation of Extended Care.

86. At all relevant times hereto, Defendant, Eric Rothner actively participated in the affairs of Extended Care in a way that placed Center Home for Hispanic **Elderly** residents, including Elsa Ramos, at risk for injury.

87. At all relevant times hereto, Defendant, Eric Rothner knew or should have known his active interference with Center Home for Hispanic **Elderly's** operations would or could place Center Home for Hispanic **Elderly's** residents, including Elsa Ramos, at risk for injury.

88. At all relevant times hereto, Defendant, Eric Rothner knew or should have known his active interference with Extended Care's operations would or could place Center Home for Hispanic **Elderly's** residents, including Elsa Ramos, at risk for injury.

89. At all relevant times hereto, Defendant, Eric Rothner implemented and mandated a budget that Center Home for Hispanic **Elderly** was directed by Defendant, Eric Rothner to adhere to.

90. At all relevant times hereto, Defendant, Eric Rothner knew or should have known the budget he directed Center Home for Hispanic **Elderly** during all relevant times hereto, to implement was not sufficient as concerned the day-to-day care of Center Home for Hispanic **Elderly** residents, including Elsa Ramos.

91. Upon information and belief, at all relevant times hereto, Defendant, Eric Rothner directed Center Home for Hispanic **Elderly** to decrease its nursing personal staff.

92. Upon information and belief, at all relevant times hereto, Defendant. Eric Rothner was aware of inadequate staffing concerns made to employee's of Extended Care, including Eric Rothner himself.

93. At all relevant times hereto, Defendant, Eric Rothner mandated through his control of Extended Care, Center Home for Hispanic **Elderly's** resident care policies.

94. At all relevant times hereto, Defendant, Eric Rothner knew or should have known Center Home for Hispanic **Elderly** residents, including Elsa Ramos, required services provided by qualified staff in order to meet the care requirements of each and every Center Home for Hispanic **Elderly** resident, including Elsa Ramos.

95. At all relevant times hereto, Defendant, Eric Rothner failed to provide and/or ensure that Center Home for Hispanic **Elderly** employed a nursing department that was properly trained.

96. At all relevant times hereto, Defendant, Eric Rothner failed to ensure that Center Home for Hispanic **Elderly** adhered to rules and regulations designed to protect the health and safety of each and every resident of Center Home for Hispanic **Elderly**, including Elsa Ramos.

97. At all relevant times hereto, Defendant, Eric Rothner maintained the authority to hire and fire employees of Center Home for Hispanic **Elderly**.

98. Upon information and belief, at all relevant times hereto, Defendant, Eric Rothner received weekly census reports from Center Home for Hispanic **Elderly**.

99. Upon information and belief, at all relevant times hereto, Defendant, Eric Rothner received monthly budgetary reports from Extended Care and/or Glen Health as it concerned Center Home for Hispanic **Elderly's** annual budget forecast.

100. At all relevant limes hereto, Defendant, Eric Rothner maintained final authority as to Center Home for Hispanic **Elderly's** annual budget requirements.

101. Upon information and belief, at all relevant times hereto, Defendant, Eric Rothner received weekly consultant reports from person(s) employed by Extended Care and or Glen Health as such reports concerned Center Home for Hispanic **Elderly**.

102. Upon information and belief, at all relevant times hereto, Defendant, Eric Rothner knew of complaints of inadequate staffing at Center Home for Hispanic **Elderly** and implemented budget cuts despite said complaints.

103. At all relevant times hereto, Defendant, Eric Rothner knew or should have known that budget cuts within the nursing department of Center Home for Hispanic **Elderly**, would or could endanger residents of Center Home for Hispanic **Elderly**, including Elsa Ramos.

104. Upon information and belief, at all relevant limes hereto, Defendant, Eric Rothner ordered budget cuts with Center Home for Hispanic **Elderly's** nursing department in order to minimize operating costs at Center Home for Hispanic **Elderly** and limit Center Home for Hispanic **Elderly's** capital expenditures, with the intent to increase Eric Rothner's personal earnings.

105. At all relevant times hereto, Defendant, Eric Rothner was a member of Center Home for Hispanic **Elderly's** Governing Board.

106. At all relevant times hereto, Defendant, Eric Rothner as a member of Center Home for Hispanic **Elderly's** Governing Board failed to act as a reasonable Board member by failing to exercise reasonable care when he knew or should have known the budget which he mandated Center Home for Hispanic **Elderly** adhere to was inadequate for provision of adequate and proper care and supervision of Center Home for Hispanic **Elderly** residents, nursing and personal care needs, including, Elsa Ramos.

107. At all relevant times hereto, Defendant, Eric Rothner knew or should have known that it was foreseeable from his many years as a nursing home owner/operator that budget cuts and low staffing would or could cause residents of Center Home for Hispanic **Elderly** to be at risk for improper supervision due to a lack of capacity for Center Home for Hispanic **Elderly** to provide adequate and proper care and supervision with a low staff-to-resident ratio.

108. At all relevant limes hereto, Defendant, Eric Rothner was the majority shareholder of Center Home for Hispanic **Elderly's** parent company, Extended Care.

109. At all relevant times hereto, Defendant, Eric Rothner was the majority shareholder of Center Home for Hispanic **Elderly's** defacto landlord, Center Home Property.

110. As a direct and proximate result of the Defendant, Rothner's direct participation in the affairs of Center Home for Hispanic **Elderly**, which surpassed the control exercised as a normal incident of a Nursing Home owner/operator, and/or Governing Body Member, thereby creating the conditions leading to Center Home for Hispanic **Elderly**, improper staffing; improper resident supervision; improper provision for activity related programs; improper provision for training of staff; improper provision for adequate funds available for the skilled nursing facility to provide adequate and proper care and services to allow residents, including Elsa Ramos, to receive proper wound care; and improper directives regarding the nursing facilities autonomy in revising budgets and policy and procedures to meet the facility population requirements; whereby the Defendant, Rothner carelessly and negligently managed, maintained, controlled, owned and/or operated Center Home for Hispanic **Elderly** in such a manner causing Elsa Ramos to suffer from: aspiration pneumonia, MRSA, Stage IV pressure sore to her coccyx and pressure sores to her bilateral heels, which subsequently led to Ms. Ramos requiring painful surgical procedures and mechanical ventilation malnutrition.

111. As a direct and proximate result of one or more of the Defendant, Rothner's direct participation in the affairs of Center Home for Hispanic **Elderly**, which surpassed the control exercised as a normal incident of a Nursing Home owner/operator and/or Governing Body member, thereby creating the conditions leading to Center Home for Hispanic **Elderly**, improper staffing; improper resident supervision; improper provision for activity related programs: improper provision for training of staff; improper provision for adequate funds available for the skilled nursing facility to provide adequate and proper care and services to allow residents, including Center Home for Hispanic **Elderly**, to receive proper wound care; and improper directives regarding the nursing facilities autonomy in revising budgets and policy and procedures to meet the facility population requirements; whereby the Defendant, Rothner carelessly and negligently managed, maintained, controlled, owned and/or operated Center Home for Hispanic **Elderly** in such a manner causing Elsa Ramos to suffer pecuniary and personal loss including but not limited to disability, pain and suffering, loss of normal life, and expenses for medical care.

WHEREFORE, the Plaintiff, HUMBERTO RAMOS, AS INDEPENDENT ADMINISTRATOR FOR THE ESTATE OF ELSA RAMOS (DECEASED), prays for judgment against the Defendant, Eric Rothner in an amount sufficient to satisfy jurisdictional requirements and other relief the Court deems just and proper. Plaintiff demands trial by jury.

<<signature>>

Jeffrey Schlapp

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